



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

PHYSICIAN MANAGEMENT SERVICES
DBA INJURY 1 TREATMENT CENTER

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-14-2062-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

MARCH 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Chartis Insurance has not paid for the medical services for [Claimant] in accordance with applicable state law and regulations for the patient's Clinical Interview."

Amount in Dispute: \$1,142.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "New Hampshire Insurance Company is maintaining their position that the \$1142.30 for the 4/16/2013 date of service is not owed to the requestor."

Response submitted by: AIG Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2013	CPT Code 90791 (X5) Psychiatric Diagnostic Evaluation	\$1,052.30	\$236.43
	CPT Code 90889 Report Preparation	\$90.00	\$0.00
TOTAL		\$1,142.30	\$236.43

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - D19-Claim/service lacks physician/operative or other supporting documentation.
 - VA02-Invalid number of units.
 - 96-Non-covered charge(s).
 - VF18-Not covered.

Issues

1. Does the documentation support billing code 90791? Is the requestor entitled to reimbursement?
2. Does the documentation support billing code 90889? Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied reimbursement for the disputed psychiatric evaluation, code 90791, based upon "D19-Claim/service lacks physician/operative or other supporting documentation."

CPT code 90791 is defined as "Psychiatric diagnostic evaluation."

A review of the submitted billing and medical records finds that the requestor billed for five units of code 90791. The report indicates that one hour was billed for reviewing records; two hours for the clinical interview; and two hours for preparing the report. The requestor is billing for time that was not actual face-to-face time with the claimant performing the evaluation; therefore, the billing of five units is inappropriate. Per the CPT code descriptor this is not a timed procedure code. The Division finds that reimbursement for code 90791 as the following:

Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2013 DWC conversion factor for this service 55.3.

The Medicare Conversion Factor is 34.023.

The Medicare participating amount is \$145.46.

Review of Box 32 on the CMS-1500 the services were rendered in zip code 76705, which is located in Waco, Texas; therefore, the Medicare locality is "Rest of Texas."

Using the above formula, the MAR is \$236.43. The respondent paid \$0.00. As a result, the requestor is entitled to reimbursement of \$236.43.

2. The requestor also billed for CPT code 90889 defined as "Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers." The requestor did not submit a separate report from 90791 to support billing code 90889. In addition, who the report was for to support billing CPT code 90889. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$236.43.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$236.43 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	02/20/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.